DEPERSONALIZATION[1]

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Many years ago I had the opportunity of observing a group of political female prisoners in Nazi Germany, whose reactions I described in a previous paper (11). To my surprise I found that during the first weeks or months of arrest, many of these rather normal individuals developed states of depersonalization, evidently in response to their traumatic experiences.

Up to then I had not encountered this phenomenon in any of my analytic patients. Thus, all I noticed and mentioned in my paper was the transparent connection of such states with the universal reaction of prisoners to the narcissistic blow inflicted by their arrest: the feeling that "this could not possibly have happened to *them*." Since then the psychoanalytic study of depersonalization in some of my patients has permitted me to form more concise ideas about this condition, which I should like to present.

Let us first briefly delimit the kind of experience to which this discussion will refer. Even though depersonalization certainly involves a disturbance of object relations, it is an experience pertaining either to the bodily or to the mental self. In the first case, the person will complain that his body or rather certain parts of the body do not feel like his own, as belonging to him. He may describe them as being estranged from himself or as being dead. This experience may go along with subjective sensations of numbness and of change of size and volume of the estranged body parts. The person may try to touch and feel them in order to convince himself that they are really "his." Not rarely may we detect states of depersonalization pertaining to the genitals and to the sexual

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act, which at first sight may impress us as cases of impotence or frigidity. When carefully questioned, such patients will report that they experience their genital as dead, as estranged, as not being their own. Male patients of this type may suffer from psychic impotence, but they may have erective potency, be able to perform the sexual act, have an ejaculation, and even some kind of orgastic experience. But in this case they perceive themselves as going through the act without being "present"; their penis performs as if it were not their own. Whenever the depersonalization extends to the mental self, there is a feeling of unreality of the self and of being "outside of the self." The depersonalized patient will think, react, act; but his experience is that of a detached spectator who is observing another person's performance. Not only his actions but his own thought processes appear to him unfamiliar and strange. As mentioned by Schilder (18), acute experiences of psychic depersonalization frequently start with an attack of dizziness. Patients often complain about their inability to imagine visually familiar persons and things (9). While some patients have alternating or combined experiences of bodily and mental depersonalization, others may suffer only from either bodily or mental self-estrangement.

It is striking and characteristic that depersonalization is an experience which very often does not find any objective expression. Sometimes patients may report that they are just going into a depersonalized state or that they were "outside" and are now "back again," without giving evidence of any change in their affectomotor expression, in their thought processes, their behavior or otherwise.

A perusal of psychoanalytic literature shows that the term depersonalization is broadly applied to phenomena which, though closely related, are somewhat different in nature. Some authors, such as Nunberg (13) and Schilder (18), include in it the feelings of estrangement and unreality with regard to the object world which often, but by no means always, accompany it. Others restrict the term to the type of experience which I have described above. That depersonalization arises from a disturbance in a person's relation with his own self has been emphasized, e.g., by Federn, most clearly in his paper "The Ego as Subject and Object

in Narcissism" (5). The *Psychiatric Dictionary* by Hinsie and Shatzky (10) stresses the same point, but defines depersonalization as "the process of being dissolved, of losing the identity, personality, the I. A mental phenomenon characterized by loss of the sense of reality of oneself. It often carries with it the loss of reality of others and of the environment." This definition equates depersonalization with those experiences of loss of identity which we find so frequently in schizophrenics.

However, persons suffering from sporadic, transitory, or even prolonged states of depersonalization by no means always show a loss of identity. And many borderline or schizophrenic patients who are constantly concerned with the question of their identity, of "who am I, what am I really?" do not complain about feelings of depersonalization. In fact, the experience of depersonalization, though indicative of a narcissistic disturbance, is not limited to psychotics. We can observe it even in normal persons, after trauma, and in neurotics, especially those who show a narcissistic personality structure.

Such patients need not suffer from inhibition or lack of affects. But pathological processes causing severe emotional inhibition or blocking or affective emptiness may find expression in states of emotional detachment to the point of depersonalization. Evidently the vividness of the "I"-experience is linked up with and dependent upon the degree of emotional aliveness, and gets lost to the extent to which the affects are held down or are "dying." But such states of emotional death as may gradually develop in severely depressive and in schizophrenic persons have a different quality than experiences of depersonalization that set in acutely. They may lack, especially, the frightening experience of becoming suddenly the outside observer of the performing part of the self. In psychotics, true experiences of depersonalization frequently appear at the initial stage of the psychosis. It is my impression that they may develop as a kind of midway phenomenon in processes which eventually lead to generalized states of inner death, of self-extinction with loss of identity.

Before presenting clinical material, I shall survey briefly some previous psychoanalytic studies on depersonalization.

That this phenomenon involves a split in the ego has been

particularly emphasized by Nunberg (13). According to him, depersonalization is always a response to the loss, especially the sudden loss, of love or of the love object: "The perception of the loss of a love object or the lowering of libido quantities is accompanied by the feeling that the reality of the perceptions and sensations of the ego has been lost. That destructive instincts are released is indicated by the painful complaints of patients in this state. . . . Since the complaints of the patients may be interpreted as castration complaints . . . the conclusion is therefore justified that identification of the ego with the genitals occurs . . . the feelings of estrangement are the direct result of the *sudden* transposition of the libido from the object to the ego."

Schilder (19) characterizes depersonalization as a picture "which occurs when the individual does not dare to place his libido either in the outside world or in his own body." Significantly, he regards sadomasochism (besides voyeurism) as a most important component. Bergler and Eidelberg (2) regard depersonalization as a defense against anal exhibitionism which is transformed into voyeurism and accepted by the ego in the form of self-observation. They point to the role of denial in depersonalization.

Oberndorf, in his paper "The Role of Anxiety in Depersonalization" (17), goes back to Freud's analysis of *déjà vu,* in which estrangement and depersonalization are viewed as defense mechanisms tending to hide something from the ego. Oberndorf stresses especially the erotization of thought and the formation of a superego inharmonious with the body ego (feminine superego in a man and masculine superego in a woman), and that this disharmony leads to a repression of the alien element, which in turn causes the feeling of estrangement. The cases he describes are supposed to show depersonalization as a specific defense against anxiety, a phenomenon of simulation of death closely related to the "playing dead" defense used by animals when in great danger.

More recently, Blank (4) described and compared the mechanisms underlying states of depression, hypomania and depersonalization in a young female patient. He defines depersonalization as "an emergency defense against the threatened eruption into consciousness of a massive complex of feelings of deprivation, rage and anxiety"; he believes that "depersonalization was called

into play when the hypomanic defense failed to keep dangerous affects in repression."

As a metapsychological description of the state, the formulations by Fenichel (7) are the clearest. But Fenichel omits consideration of the role of aggression, which had been correctly stressed by Nunberg. "In states of estrangement," he says, "an increased cathexis of the body is countered by defensive reactions; in depersonalization, an increased narcissistic cathexis of mental processes is handled in the same way. In depersonalization overcharged feelings or conceptions are repressed. . . . The experiences of estrangement and depersonalization are due to a special type of defense, namely, to a countercathexis against one's own feelings which had been altered and intensified by a preceding increase of narcissism. The results of this increase are perceived as unpleasant by the ego which therefore undertakes defensive measures against them. These defensive measures may sometimes consist in a reactive withdrawal of libido; as a rule, however, they are built up by countercathexis." Fenichel quotes Schilder's (18) statements that in depersonalization we have two conflicting directions, namely, the directions toward and against feelings of body sensations, and furthermore that "the organ which carries the narcissistic cathexis is the one more subjected to depersonalization."

Before presenting my own ideas on depersonalization, I must emphasize that the clinical material on which they are based does not stem from psychotics, but from normal and neurotic persons who lend themselves better to psychoanalytic exploration. However, comparative observations of psychotic cases suggest that the nature of the processes leading to depersonalization is essentially the same in normal, neurotic, and psychotic persons.

I believe it will be fruitful first to examine the psychological roots and the nature of this phenomenon as it appeared in the comparatively normal group of female political prisoners under the traumatic impact of sudden arrest and of cross-examinations. For this purpose, I shall have to repeat and elaborate upon some pertinent observations reported in the above-mentioned article (11). There I described that commonly the prisoners reacted to their sudden, unexpected arrest with a transitory state of shock,

general stupefaction, and considerable confusion, accompanied by feelings of unreality about themselves and their environment. During this period many of them would develop symptoms and a behavior indicative of sudden, general, severe regression to a more or less infantile position. But after a few days, this state would usually subside; the prisoners would recover their sense of reality; they would attempt to face, accept, adjust to their unfortunate situation, and to regain their previous adult level. After some weeks most of them were in a sufficiently good emotional balance again to sleep and eat normally, to take up manual and intellectual work, to enjoy reading and the companionship of their cellmates. On the whole, it was remarkable how well the ego and the object relations of this rather stable group withstood the impact of all the hardships. But naturally, during the harassing period pending trial, the prisoners would suffer from anxieties and from continuous vacillations between sad-depressed and hopeful-optimistic moods and attitudes. And, especially during the first months, many complained about recurring experiences of depersonalization, from which they had never suffered in the past. These states would develop particularly after terrifying cross-examinations and similar upsetting incidents which were usually followed by brief periods of emotional upheaval and distress.

When called for such interrogations, many prisoners would suddenly become intensely activated in anticipation of a battle of wits with the prosecutors. Those who succeeded in being well composed, highly alert, and shrewd in their answers reported that they had managed to overcome their fears by deliberately trying to get into a cold state of detachment which certainly came rather close to depersonalization. In fact, this detachment would often lead up to experiences of having no body, no sensations, no feelings, of having indeed nothing left but a coldly fighting brain. The defensive function of the emotional detachment was clearly evident and very successful in such situations, inasmuch as anxiety and other undesirable emotions had disappeared, and a high level of ego functioning could be maintained with control and direction of aggression into the proper channels of organized thinking and behavior.

But in the wake of such interrogations and of other injurious

events, in which prison life abounded, highly unpleasurable and unwanted experiences of depersonalization would sporadically recur. Prisoners would wake up at night with feelings that their limbs or their face did not belong to them. They would anxiously touch the estranged body parts, trying to recover the feeling of intactness of their body self. During the day they would be suddenly overcome by frightening experiences of psychic self-estrangement; with feelings of being outside their self and of watching themselves think, talk, or act, as though they were another person, and the like.

From the prisoners' reactions to the cross-examinations we can infer that these true states of depersonalization were posttraumatic manifestations and originated in a continued defensive struggle aiming at mastery of the traumatic situations. In order to study the processes which brought on this particular pathology, we must gain clearer insight into the nature of the traumata to which the prisoners were subjected and of the conflicts aroused by their experiences.

The sudden arrest and imprisonment imposed on these persons a drastic and highly painful change in their entire life situation. To understand the traumatic impact of this change, we must remember that our feeling of "familiarity" with regard to the social and emotional climate in which we live originates not only in the libidinous ties to our environment but, besides, in a great variety of identifications with it. They include ego-superego identifications as well as all kinds of subtle identifications on a more primitive narcissistic level, partly of the "appersonation" type. We may tend to underrate the extent to which the consistency and homogeneity, and hence the stability, of our self-image depend on the compatibility, harmonious interplay, and collaboration of those innumerable identifications with all the familiar personal and impersonal, concrete and abstract objects of our past and present life and environment. They involve not only our family, our home and place of residence, our work and work situation, our property and personal belongings, but also the social, vocational, national, racial, religious or ideological group to which we "belong."

We know that abrupt changes from the familiar to a new,

strange and unfamiliar scene or environment, even in cases where the change is most pleasurable, can bring about mild, fleeting experiences of depersonalization. But these prisoners, forcefully expelled from the world in which they had formerly lived, deprived of partners, relatives and friends, of their work, interests and pleasures, of decent food, personal belongings and even of their clothing, had been suddenly thrown into a most repulsive new role and existence. Locked up in a cell, treated as severe criminals without regard to their past social and individual position, exposed to the silent or noisy, humiliating or brutal assaults by the living conditions in prison and to the ordeal of a harassing trial with merciless cross-examinations, they found themselves not only in a most unfamiliar but in a very frightening, degrading, helpless, and hopeless situation, facing a prospect of some years, at best, in a penitentiary. The sudden impact of the arrest, the forcefulness and repetitiveness of subsequent traumatic experiences, and the helplessness of their entire condition were bound to shake the foundation on which their life and their self heretofore had rested. These events threatened to undermine and break the array of all those identifications on which the image of their old, independent self was founded, and to replace this concept with a new, intolerable one based on identifications with the degraded, criminal world in which they now lived.

There were many evidences that the defense struggles of these prisoners were essentially directed against this danger. In my previous paper I described how the political prisoners managed eventually to protect themselves by very sound, effective safeguards, to which I shall refer later. But in the beginning their weakened ego was unable to cope adequately with the dangerous influences of their new environment, and unfortunately the conditions in prison and the ever-recurring traumatic events stirred up inner conflicts which propelled them toward acceptance of the role of criminals.

To be sure, legally these political prisoners were criminals, inasmuch as they had committed one of the worst crimes: high treason. Whereas practically none of them before being arrested had ever consciously doubted his moral right to rebel against the current regime, the arrest and imprisonment, which meant defeat

and—unconsciously—punishment, tended to affect their moral position. Indeed, the prisoners suffered invariably from doubts and guilt feelings. Only some among them had serious doubts of an ideological nature; later on, they confessed that they had temporarily felt confused and tempted to condemn their former belief and to accept the Nazi ideology. But in most of them the guilt conflicts were consciously centered about self-reproaches for having involved their family and friends in their calamity. The intensity and the content of these guilt conflicts, which paved the road to depressive and moral-masochistic reactions, were indicative of a revival of infantile conflicts with the parental authorities even in those whose actions had not been primarily thus motivated. Of course, the helpless situation of imprisonment as such tended to smother the tremendous hostility it provoked and to veer it toward the self.

But the prisoners' political and moral convictions might have lent them greater support in their inner struggles, had they not been exposed to the instinctual dangers arising from the world in which they now lived. In my previous paper, I described in detail the offensive and infectious atmosphere generally prevailing in prisons: an atmophere created by the criminal inmates as much as by the sadistic-seductive parental attitudes of guards, prison officials and cross-examiners. The vicious influence of this pregenital, sadomasochistic atmosphere, which invited regressive infantile identifications and relations with the delinquent environment, was probably the most pathogenic factor in the instinctual and guilt conflicts of these prisoners.

This influence asserted itself most dangerously in situations of cross-examination, although it was by no means limited to them. We are familiar with the psychological tricks of cross-examiners in countries under dictatorship. They try to obtain confessions not only by using a brutal, sadistic approach, but also by suave, seductive, emotional, and ideological appeal. This is the gravest danger, inasmuch as it tempts the lonesome prisoner to enter into a highly erotized, sadomasochistic, and infantile-dependent relationship to his torturers. Reports from persons who yielded to such an appeal and confessed leave no doubt that this was the

inner danger the prisoners attempted to ward off by an emotional detachment which made them "invulnerable."

Indeed during the interrogation, which offered an opportunity for counterattack, the ego had a good chance to fight successfully against the dangers from without and within. The realistic battle with the enemy required an overinvestment of the thought processes, which permitted a withdrawal of cathexis from the feelings to the point of complete detachment from the brutal and seductive adversary as well as from the vulnerable self that was tempted to respond to the seduction. This hypercathexis of the thought processes made them a reasonable vehicle for aggressive discharge to the outside, and concomitantly served as a countercathexis against the inner dangers of either masochistic submission or sadistic explosion. In this situation the defensive process could still maintain the level of a forceful repression and inhibition of threatening id impulses.

But when brought back to their cells the overexcited prisoners, deprived of a realistic object and outlet for their hostility, would suddenly feel utterly deflated and disturbed. Their transitory feeling of triumphant elation would yield to the depressing insight that, however strong the defense, final defeat had to be expected anyhow. Then the danger of a renewed, sudden, pathological regressive process, which might overpower the ego, became acute. In fact, after such cross-examinations the prisoners would find it very hard to return to reasonable activities. For many days they could not resist the temptation to go on, at least in fantasy, with furious, frustrating, and exhausting fights against their persecutors. In these imaginary fights, wild sadomasochistic fantasies often would break through to the surface. Besides, during such periods they would tend to infringe the prison rules and get into serious trouble with the guards and authorities.

It is noteworthy that the experiences of depersonalization would mostly develop at such times when the prisoners were disturbed rather than depressed; when they would vacillate between relapses into excited pregenital fantasy life and actions, and periods of normal behavior and quiet work. They were indicative of a failure of the superego and ego to prevent temporary regression and instinctual defusion, and to gain mastery over

the tremendous hostility provoked by the traumatic experiences. Unable to ward off temporary invasions of unacceptable infantile id impulses by means of normal defenses, the weakened ego would thus vacillate between two contradictory states. Relinquishing normal ethical standards and behavior, it would for some time permit indulgence in pregenital, sadomasochistic "delinquency," and then re-establish its past standards and return to a normal level of behavior and functioning.

In this situation of failing repression, the ego, trying to regain its lost position, would call on an ultimate, infinitely more primitive defensive device. Reflecting the schism between the alternating ego states, a split between two opposing self-representations would occur. The ego would attempt to reaffirm and restore its intactness by detaching, disavowing, and denying the existence of the regressed, "criminal" self, or rather by pretending its nonexistence.

It is of interest in this connection that as far as I could observe, the body parts tending to become estranged and dead were commonly the face, especially the area of the mouth, and the arms and hands; i.e., those body parts which were unconsciously or even consciously involved in fantasies of attacking and being attacked.

Depersonalization thus appears to be the pathological result of a conflict within the ego, between the part that has accepted and the part that attempts to undo identification with a degraded object image; in this case, with the image of the infantile, pregenital, sadomasochistic, castrated criminal. (It is significant that in those few prisoners who felt tempted to turn Nazi, this identification established itself under the guise of a new ideal contradictory to their previous one.) The nature of the primitive identification processes preceding and leading to depersonalization will be exemplified more clearly in the clinical cases.

I said in the beginning that, at first sight, depersonalization seemed to be a response to the severe narcissistic blow inflicted by the arrest, and to express the prisoners' feeling that "this could not possibly have happened to them." This interpretation is still valid, as long as we do not neglect the complexity of the ego's responses to the traumatizing external events. What could not and should not have happened is, evidently, less the narcissistic injury

from without than the narcissistic blow inflicted from within upon an ego that has experienced weakness vis-à-vis the threat of sudden regression, instinctual defusion, and destructive drive invasion.

It was indeed interesting to watch how the states of depersonalization would subside to the extent to which the prisoners were able to recover their past ego and superego strength, to return to regular, consistent manual and intellectual work, and to renounce indulgence either in masochistic brooding over their misfortune or in sadistic—real or fantasied—attacks on their persecutors.

I mentioned above the effective safeguards against the dangerous influences of their environment, which were gradually established by these prisoners. Their defensive devices were clearly, and partly consciously, designed to draw a line of demarcation between the political and criminal inmates, and to emphasize the difference in the level of their personalities. Thus the political prisoners would consolidate into a strictly separate group that would reject and prohibit intimacy of any kind with the criminals as well as with the Nazi prison authorities. They would introduce a firm, ethical code of behavior, and especially encourage reading, intellectual work and any type of sublimation. Among the many rules, those stood out which aimed to promote bodily cleanliness and neatness, to curb oral greed, to insist on sharing of food and other privileges, to develop kind mutual relations, and to prevent open rebellion as well as weak submission to the guards and other prison authorities by the adoption of coldly polite, dignified attitudes. Quite obviously these group regulations were meant to offer special protection from pregenital and sadomasochistic trends and seductions.

We shall presently test the validity of these assumptions by examining experiences of depersonalization in some clinical cases.

Mrs. A., a young mother suffering from an anxiety hysteria, has a charming little daughter of five to whom she is attached by very close narcissistic ties. She has transferred to the child fantasies originating in her relationship to her powerful mother. In fact, her imagination has equipped the little girl with an illusory penis and even transformed her into a penis belonging to herself;

fantasies that offer her constant narcissistic supply without the fears and hostility aroused by her dominating mother.

One morning, the young woman has to take over the care of her daughter's little boy friend of the same age. Led to the bathroom, both children take down their pants and expose their genitals. The mother looks and cannot avoid perception of the difference. At this moment her sight becomes blurred, she feels dizzy, detached, and anxiety arises. After a short while she experiences a previously unknown, sudden, transitory feeling of depersonalization; a feeling of being unreal, of being no longer herself.

What has happened? The perception of the little girl's genital in comparison with that of the boy had destroyed the patient's phallic illusions and inflicted a severe castration shock upon her. She reacted with a sudden libidinal withdrawal and an immediate denial of the frightening perception, which found expression in her feeling of detachment and her visual disturbance.

The analytic material left no doubt that her initial defense and symptom formation helped her to ward off her sudden hostile, sadistic reactions to the "castrated" as well as to the "phallic" child. Instead of responding to the disillusioning perception with an outburst of open hostility, she put them both temporarily "out of existence" by means of a primitive denial mechanism which brought about a visual disturbance. However, this defense and symptom formation failed to protect her from repercussions of the frightening perception on her own self. Her narcissistic relationship to the little girl predisposed her to respond to her withdrawal from the child with a temporary narcissistic regression causing an immediate shift of libido and aggression to herself. This transformed her conflict with the love object into a narcissistic conflict: a conflict between two opposing identifications, leading to a split in the ego. Inasmuch as the mother had loved the child, she felt certainly tempted to accept what had now turned into a masochistic identification with the "castrated" little daughter. But in so far as she had hated and retreated from the deflated object, she tried to undo this identification. By replacing and restoring the lost phallic object with a reactively hypercathected phallic self-image, she now could detach, decathect and disavow

the "castrated" self. Thus she magically eliminated it in the same way as she had initially eliminated the external love object.

We see the analogy between this patient and the prisoners. In her case, too, the state of depersonalization arises from an experience which, because of the patient's neurosis, has a traumatic effect. Again the shock seems to provoke a brief regressive process with sudden drive defusion, stirring up an amount of anxiety and hostility that cannot be mastered by repression but requires a more primitive and drastic defensive device.

What makes this example instructive is that we can observe two phases in the process of symptom formation. The first, which brings on blurred vision, relates to her conflict with the object. The second, which leads to depersonalization, reflects a conflict within the ego and pertains to the self. The case reveals a significant fact regarding the predisposition to depersonalization. It certainly shows the validity of Nunberg's statements inasmuch as depersonalization may develop as a response to a sudden loss of love or of a love object. But the prerequisite for this particular symptom formation in my patient was the narcissistic nature of her object relationship to the child, which caused her to respond to the shocking sight of the latter's genital with an immediate withdrawal and narcissistic regression.

The next patient, Mr. B., was a highly gifted professional man in his thirties; likewise a hysterical personality type, although with obsessional features. Since his childhood he had suffered from anxieties, from depressed states, and from recurring brief, frightening experiences of depersonalization. He described them beautifully as feelings of being "insubstantial, without a shadow, so to speak—except for the persistent observer of the whole process." Otherwise the patient had a very intense emotional life and showed warm feeling qualities. He was happily married, worked hard, and had very rich sublimations.

His states of depersonalization had started when he was five, after the death of his mother who died during childbirth. The little boy had been prepared for the arrival of a baby. During her pregnancy his mother had tried to place him in a kindergarten, but there he had cried for her so bitterly and consistently that he

had to be sent home. One day, suddenly, the mother had left for the hospital. She never returned. He vividly remembered the grownups weeping and whispering in the room next door, and his grandmother saying: "As long as there is life, there is hope"; this referred to the newborn, who some hours later died too. The next day the child found himself in the grieving grandmother's apartment, removed from his home, his room, his toys; deserted by his mother and his old nurse; and, for a brief period, also separated from his father. No explanations of what had happened were given to him then or for years after.

Left to his own surmises and fantastic interpretations, he went into a disoriented, depersonalized state, unable to believe that he could be the same boy as before the tragic events. He had become a different, in fact, a bad boy. To be sure, these events had been most traumatic. However, the analysis showed that their impact on the child was so very grave because of his overclose and overdependent pregenital relationship to his mother, and the overpermissiveness of his nurse who had weakly submitted to all his tyrannical demands. The mother's attempt to place him in a kindergarten during her pregnancy thus had provoked an unusually passionate rivalry conflict which found expression in his severe separation anxieties. Consequently, her sudden, unexpected, and unexplained death, followed by the loss of his nurse and the temporary separation from his father, left him feeling utterly frightened and abandoned. The analysis revealed that the circumstances of his mother's death had mobilized wild primal-scene fantasies visualizing the mother as a victim of her passion for the father, and the father as the sexual murderer of the mother. The violence of his fantasies became apparent in his vivid memory of a picture ornamenting the parental bedroom: a poorly dressed couple, closely embraced, is shown running away through thunder and lightning, in wild mountain scenery; the young man holds a big horn in his hand.

Actually the father was a kind man; he stayed with the boy, in the home of relatives, and gave him constant love and affection. But even though he glorified the mother and spoke of her as of an angel, after her death he kept a succession of mistresses, partly

in a separate apartment, frankly defending his hedonistic attitude toward life.

The result was that the patient developed most contradictory feelings toward his father. He was deeply attached to him; but he severely condemned and detached himself not only from the father's "immoral" attitudes, but likewise from his own pre-oedipal past with mother and nurse. When the latter visited him, in his beginning latency, he found her "disgusting" and felt completely estranged. Subsequently he developed a "family romance" fantasy, which he maintained throughout his adolescence, of being the son of an aristocratic British family. Eventually he turned into a puritan, by forming a reactive ego ideal founded on the myth of his angelic mother and on his family-romance notions. His puritanism found reinforcement in the restrictive attitudes of his severe grandmother. In general he adhered to his very stern moral code and convictions. But he tended to develop highly erotized, latent homosexual, masochistic relations to older men, especially superiors, which involved considerable acting out. Characteristically, the patient married a girl of socially higher background than his own. But although he was happily married, his home life was frequently disturbed by stormy family scenes between himself, his temperamental wife, and his impulsive children. And one special field of sublimations, kept strictly isolated from his professional work, permitted him secret indulgence in very regressive sadomasochistic, pregenital fantasies (including fantasies of mutual devouring) under the beautiful but rather thin disguise of a highly idealized, aesthetic pursuit. His states of depersonalization developed evidently as a result of such unacceptable intrusions into his ego of regressive pregenital, sadomasochistic "primal-scene" identifications with his parents.

What connects this patient with the next two cases are certain features in his ego and superego structure. I pointed to his father's rather shaky superego which had caused the patient to build up a reactive ego ideal and an overstrict superego. In general his superego was perfectly effective, and his ego well developed and on a high level. Nevertheless, under the cloak of an "ideal" pursuit and of an "ideal" marriage with a socially "high-class" girl, his identifications with the immoral-sadistic father and with

a correspondingly masochistic pregenital mother image had gained entrance into his superego which, thus deceived, permitted relapses by the ego into an acting out of his regressive fantasies, in limited areas.

In his case, the states of depersonalization certainly originated in the severely traumatic childhood events. However, the predisposing pathogenic factors—the pregenital seductions by mother and nurse, the harmful seductive influence of a father with a defective superego and ego, and the resulting contradictions in his own personality—must not be underrated, and were probably responsible for the continuous recurrence of depersonalized states throughout his childhod and in adult life. It is significant that in the pathogenesis of the next two patients, the factors here mentioned play an even more striking part.

Contrary to the preceding cases of acute, transitory experiences of depersonalization arising in emotionally uninhibited, hysterical personality types, the depersonalized states in my third patient, Mr. C., developed on the basis of severe, generalized affective inhibitions.[2] He was essentially a compulsive-depressive young man, whose main complaint was a chronic emotional detachment that would sometimes lead up to experiences of depersonalization. He belonged to the group I mentioned in the beginning, of persons who either suffer from psychic impotence or, at other times, go through the sexual act without enjoyment and true orgastic experience, in a mildly depersonalized state, watching themselves perform.

In my previous paper (12) I discussed the elaborate defense structure built up by this patient essentially for the purpose of warding off severely sadomasochistic, pregenital impulses. Moreover, I showed that his denial and projection mechanisms, which resulted in a state of painful emotional detachment, were simultaneously directed against his superego and his id, and were designed to rid him of his early preoedipal, sadomasochistic identifications with his parents, essentially his mother. I described that a break with the mother had occurred at the age of three and

[2] I have previously reported this case in a paper on "Denial and Repression" (12).

a half, when she had a near-fatal miscarriage at home—which he probably witnessed—followed by physical illness and a depressed state of several weeks' duration. From then on the patient felt open, cold hostility toward his mother, denying that he might ever have loved her. This denial was directed not only against his preoedipal attachment to her, but in particular against his identification with both mother and child. I suggested that this traumatic early childhood event, which was revived at the age of seven by the tragic death of his younger brother, might account for the preponderant use of denial in the patient's defenses.

From his transference reactions I am inclined to infer that he had responded to the first trauma already with a transitory depressed-depersonalized state which repeated itself after the death of his brother. Recent analytic material shed more light on the infantile origins of the identification—or "disidentification"—processes underlying his depersonalization.

When the patient's pregenital strivings began to break through to the surface he developed recurring gastrointestinal symptoms: nausea, colon spasms, and diarrhea. As in the past, he tried to ward off their meaning and his fear (of cancer) by denial and detachment. He ignored and neglected his illness by continuing to eat as he pleased, though with the usual lack of real enjoyment. It turned out that he felt estranged from his sick intestines and "refused to regard them as his own." He was "angry" at his guts and wanted to scold them, like this: "You behave like a naughty child, but you will have to accept and get used to what I eat!" In this situation the "angry he" plays the role of the rejecting, scolding mother who ignores the baby's sickness and forces the "bad child" (that has eaten forbidden food and lost bowel control) to submit, eat ordinary meals, and accept pain and punishment. His "sick intestines" are here equated with his sick baby brother. But in his refusal to go on a "baby diet" he is also identified with the rebellious, bad child who wants to eat what he pleases, and, besides, with the seductive mother who offers dangerous oral freedom. This is why the patient feels not only estranged from his sickness, but equally detached from the "greedy" self and unable to enjoy his unreasonable oral excesses.

This example is so very interesting because it shows collabor-

ating processes of bodily and mental self-estrangement directed against multiple identifications with different degraded, early infantile object images.

Eventually the patient found what he felt to be a perfect solution of his dilemma: the best remedy would be a bottle of good red wine; that would certainly stop his diarrhea. This slick problem solution meant to reconcile and unite mother and child: himself with his estranged, sick guts and with his indulgent, greedy self. The loving mother will give the child the bottle that he really wants and that cures him at the same time.

This incident also illuminates the patient's need for multiple projections as a support of his denial. In my earlier paper I reported that unconsciously this patient felt unjustly accused by the mother of crimes which he had not committed: the murder of the children and the poisoning, i.e., the pregnancy, the miscarriage, and sickness of his mother, and that his projections pointed to his family—essentially the mother—as the "true criminals." His estrangement from his "sick intestines" as well as from the indulging self shows basically the same tendency to deny that "he" can be the criminal. But instead of projection onto other objects, he tries in the states of self-estrangement and depersonalization to get rid of those undesirable identifications by splitting them off and disowning them.

The contradictions in this patient's behavior, the seemingly strict and punitive attitude toward his sick body, with which he disguises his negligence and unwillingness to accept temporary restrictions, are characteristic of his ego and superego structure.

In my paper I described at some length the superego pathology which accounted for the many contradictory features in his character. Compulsive traits, such as neatness, aestheticism, decency, kindness, existed side by side with isolated cold overt death wishes toward his mother and mistress. While under the pressure of a cruel, restrictive superego, he consciously brandished the torch of an ideal favoring utter instinctual (pregenital) freedom without guilt feelings. Although frankly desirous of being able to drink, whore, steal, throw away money as he pleased, he would complain about his temperate, too reasonable attitudes and his inhibitions; quite unaware that at other times he actually did drink and spend

money quite excessively and indulged in pregenital sexual fantasies and activities. He did not notice and admit his behavior, because his indulgences were certainly devoid of the vivid feeling tone and the pleasure he craved, and left him in a depressed mood. One may best characterize his personality by saying that the patient had tried, but not really achieved, to build up a consistent, compulsive personality structure. He showed contradictions in his superego and ego, which became conspicuous during adolescence as he began to suspect and frankly rebel against his restrictive and seemingly compulsive father, who in fact had similar contradictory character traits. Thus the patient had developed an alternately too restrictive and too lax, though punitive superego, and hence oscillated between manifestations of an inhibited and an impulsive ego. His auxiliary defenses (isolation, denial, detachment, projection) served to protect him from continuous drive invasions into the ego, based on pregenital, sadomasochistic identifications with his parents and his baby brother.

In this patient, as in the last one, the id had found its way into the superego under the guise of a conscious ideal. In Mr. B.'s case, it was an ideal, aesthetic pursuit, in Mr. C.'s, a frankly "delinquent" ideal of "freedom"[3] which greatly influenced his behavior. In some instances of borderline or psychotic depression where experiences of depersonalization stood out in the symptomatology, I observed that (similar to Mr. C.'s case) the patients' self-reproaches had a more realistic core than is commonly the case in melancholic depression. These patients had either gone through periods of impulsive or delinquent behavior, or at least once had planned or actually committed something "immoral" or "unforgivable."

Mr. C.'s efforts to prove that the parents—not he—were the true criminals are certainly remindful of the emotional situation of the prisoners. The difference lies in the realistic nature of the latters' circumstances. They actually lived among criminals and had good reason to feel that not only were they unjustly treated

[3] The idealization of sadomasochistic notions, in a grotesque or even delusional form, can be observed in certain paranoid schizophrenics. E.g., a severely paranoid schizophrenic boy of twenty idolizes Hitler and identifies with him. When he works he either imagines he is "Hitler bombing and invading a city" or "Hitler the martyr, dying for his nation and his cause."

as such, but their cross-examiners and prosecutors—rather than they themselves—were the "true"criminals.

Among the truly criminal inmates of the penitentiary I found one particularly interesting example of severe depression with depersonalization, which sharply highlighted this kind of conflict situation. This was a girl serving an eight-year term for complicity in robbery and murder. She had been a secretary. Her social behavior had been normal until she fell passionately in love with a criminal psychopath who enticed her to assist him in the murder and robbery of an old woman. He escaped and left her behind, holding the bag. The girl, as I just mentioned, was severely depressed; she was a model prisoner who accepted the penalty as due her, and while in the penitentiary contracted tuberculosis. She aroused my interest because she had pretended to be a political prisoner until she was found out. Then she was eager to tell me her story and confessed that she—the idealistic, rather sophisticated girl she had always believed herself to be—felt completely estranged and unreal about her criminal self, and at times could not believe that she had committed such a crime. This state of depersonalization had started even before she was apprehended. During the whole period of her enslavement to her criminal lover she had felt as though in a trance: like not being the same person, like being compelled to act as she did, etc. Her pretense of being not a criminal but a political prisoner was in line with her self-estrangement and the split in herself.

In her case we see a complete breakdown of the superego under the influence of a passion, which permitted her identification with the adored criminal love object to assert itself completely in her ego. The fact that this girl experienced her passion as being under the "hypnotic" influence of her lover brings this example close to what happens in real hypnotic states and in fugue states.[4] In hypnosis a sudden regressive process, which allows a revival of former superego-ego states, is artificially induced through the medium of the hypnotist. As to fugues, Fisher and Joseph (8)

[4] When I presented the first draft of this paper at the Austen Riggs Center, Dr. Brenman and Dr. Rapaport called my attention to the relation of depersonalization to experiences in hypnotic and fugue states.

found that they set in when murderous impulses threaten to break, or actually have broken, through to consciousness.

I must forego the wish to examine the transparent relation between hypnotic and fugue states and the state of depersonalization more thoroughly. Instead I shall report a final case example which is most illuminating with regard to the infantile origins of depersonalization. It shows the development of states of self-estrangement in childhood as a result of seductive experiences, and points again to the predisposing influence of early parental seduction and a contradictory parental superego.

Mrs. D., a young divorcee in her twenties, came for treatment because of depressive reactions and masochistic attitudes which had interfered with her love life. In spite of her symptoms the patient had unusual ego strength which manifested itself in her heroic struggle against severe illness. Since infancy she had suffered from recurring attacks of cystitis and pyelitis. Her almost chronic illness had imposed considerable physical and general ego restraint on the child and necessitated constant medical care, including very painful irrigations of the bladder. Besides, her condition for many years had prevented her from gaining urinary control. For this failure, as for her illness in general, the little girl had been incessantly and unjustly blamed by her unreasonable parents, who did their best to deny the child's real physical damage and to relieve their guilt feelings by projections and by exhibition of their own suffering. They had indeed good reason to feel guilty, inasmuch as the little girl had been subjected to continuous seductions by the therapeutic procedures which involved examinations and rather careless manipulations of the genital area. These treatments were carried out not only by the physician, but partly also by the parents, including the father. Thus, from the first years of life through the latency period, the child had been exposed to sadistic genital, urethral, and anal overstimulations that fused sexual excitement and pain. Most traumatic were the irrigations of the bladder, for which the little girl would prepare herself in anxious anticipation. Soon she learned to accept them with the support of a clever device. Before the procedure began, she would silently address her bladder and

would scold and punish it as follows: "Shame on you, bad bladder, go away and stay over there in the corner." By this magical removal of the bad and sick organ from her body she would make herself physically numb, or at least sufficiently tone down the unbearable tension and pain to lie quietly and tolerate the procedure without anxiety and rebellion. When it was terminated she would gaily release the bladder: "Now you are good again and may come back to me."

The touching simplicity of the little girl's effective device, which at least reduced her pain, did not betray its deeper meaning and the underlying instinctual conflicts which it failed to resolve.

The fact was that the therapeutic-sexual situations had a seductive effect on the father as well as on the child. He was overattached to her physically rather than emotionally and, as a memory showed, had transferred his own incestuous desires from his mother to this daughter. During the patient's adolescence he continued to behave in a seductive manner. The patient responded to her father's behavior with shock, disgust, hostility, and eventually with detachment from him, as formerly from the mother. She escaped from the unhealthy home situation first by attaching herself closely to the warm and interesting family of a girl friend. Under their beneficial, stimulating influence she started to bloom emotionally as well as intellectually. She began to study and to develop many interests and sublimations. But when she lost these friends through external circumstances, she accepted the first serious proposal she received, married, and moved away from her home town at the age of eighteen.

Not surprisingly, the patient had chosen a psychopathic husband who forced her into a severely masochistic position which was a replica of her childhood situation. For seven years she accepted and stubbornly denied her unhappiness and failure, maintaining the façade of an undisturbed marital relationship. During those years the highly intelligent and gifted girl abandoned all her own ambitions, interests, and abilities for the sake of her talented but irresponsible and parasitic husband. Accepting subordinate jobs at which she worked hard from morning till night, she lived, as it were, on a regressive and restricted ego level, in an emotionally

numb, chronically depressed-depersonalized condition remindful of her worst childhood period.

But her analysis revealed that throughout those years she had maintained a secret fantasy life that was constantly nourished by the seductive influence of the pregenital atmosphere which her partner created. This private world of hers included sexual fantasies that were almost undisguised derivatives of those tormenting childhood experiences.

The analysis of her fantasies and of her infantile memory material shed light on the deeper structure and meaning of her infantile defensive device. The "sending away" of her "bad" bladder was supposed to protect her not only from pain and hurt, but even more from the danger of violent sadistic motor, anal, and urinary outbursts and, the reverse, masochistic enjoyment of being "raped" by the father. Indeed, the little girl, wishing to retaliate and reverse the situation, had never forgotten her gleeful feelings when, at least once, she had rebelled and urinated right in the face of the attending physician.

Her talk with her bladder betrays that the treatments meant punitive measures and concomitantly sexual gratifications to her. Certainly the "bad" bladder was she herself, the bad little girl who wanted to and did indulge in incestuous pleasure, who deserved and received punishment. By ejecting the organ from her body self she could disown both crime and punishment, and displace them onto the personified bad bladder. But at the same time the "bad" bladder, which she scolded and punished, represented her "bad" parents from whom she wished to detach herself; parents who seduced and simultaneously punished her, and who—even worse—exhibited their own suffering and blamed her for it.

It is significant that the patient suffered from obsessional doubts whether she or her parents should be blamed for her misfortunes, and tried to find evidence for their guilt. Thus, like Mr. C., she felt that not she but the parents were the truly guilty ones.

It is characteristic of the patient's inherent vitality that after seven years of masochistic slavery she found the strength to rebel and to leave her husband. Again under the influence of encouraging friends, she called her "good self" back from its exile. Seizing upon her adolescent interests, she went back to college, completed

her studies, and soon made an astounding career. And at last, as a result of her treatment, she found personal happiness too in a new marriage.

Discussion and Conclusions

We have studied the conflicts and the defense processes underlying states of depersonalization, first in a group of normal persons under exceptional circumstances and then in different types of neurotic personalities.

Let me recapitulate the impressions gained from this material and reformulate my conclusions.

Apparently states of depersonalization always represent attempts at solution of a narcissistic conflict. Inasmuch as such states may be caused by sudden loss of love or of a love object, they presuppose object relationships of a narcissistic type. But this narcissistic conflict does not arise from a schism between superego and ego, as in depression. The conflict develops within the ego and has its origin in struggles between conflicting identifications.

Our material suggests that even normal people may respond with transient states of depersonalization to traumatic or even to simply unusual events. I had mentioned those mild, fleeting experiences of depersonalization which may develop when persons are suddenly placed into a strange, unfamiliar environment. It is significant that such states may be caused by changes to fascinating new surroundings to which we can certainly relate and respond very vividly and pleasurably. But delightful as it may be, we feel that we do not "belong" to this lovely new world. Evidently it invites new identifications which the ego refuses to accept immediately. This indicates that the primary cause of the disturbance is not necessarily a disruption of object relations, but a narcissistic conflict caused by discrepancies between opposing identifications. Probably, fleeting states of depersonalization of this type do not arise on the same premises as truly pathological states, such as we have described above.[5] It seems that the latter develop in situations

[5] It is interesting, though, that in patient B. feelings of depersonalization "recur in milder ways," when he is "transplanted to unfamiliar surroundings—marked by the temporary loss of home and family and friends."

where the ego is threatened by sudden regressive processes involving the ego and superego, processes resulting in drive defusion and pregenital drive invasion into these structures. Such processes may be induced by traumatic external events or by experiences which for inner reasons have a traumatic effect. They may be of brief or longer duration and may tend to recur in persons predisposed to such regressive relapses by an uneven, contradictory ego-superego structure. Furthermore, they may be indicative of a psychotic disorder.

In patient A., the narcissistic conflict situation was the least complicated. The intense hostility, aroused by the castration shock and warded off by her withdrawal from the child, certainly points to a sudden drive defusion and narcissistic regression provoked by the trauma. In her case, however, the conflict remains limited to a struggle between two contradictory self-images which reflect opposing fantasies of identification with the phallic and with the degraded, castrated daughter. This is why her experience of depersonalization is so acute, of such brief duration, and does not repeat itself.

In the other patients and in the prisoners, the emotional situation is different because the superego is involved in it. I emphasized above that the conflict leading to depersonalization is not between superego and ego, but within the ego. This does not imply, however, that the superego may not play a most significant part in the development of the conflict. Of this we found sufficient evidence in our material. In all cases excepting Mrs. A., the instability or weakening of the superego structure and the resulting contradictions were the reason for drive intrusions into the ego. They caused a real split in the ego between the part that tried to restore and maintain a normal level of behavior, resting on stable identifications, and the part that had temporarily regressed and yielded to infantile, sadomasochistic, pregenital identifications and object relations. This is why in three of the patients and in the prisoners we found periods of manifest vacillations between opposing—normal and regressive—ego states, which led either to brief but recurrent or to more enduring states of depersonalization.

Let us now turn to the special defensive operations which induce such a state. They are directed against those unacceptable

identifications and can be defined as attempts at undoing them by virtue of disowning and denying the undesirable part of the ego. Hence, this defense bears all those landmarks of primitive defense processes which I described in my paper on "Denial and Repression." In the example of the prisoners, we could see that as long as their superego and ego remained intact, repression could operate against the specific, unacceptable id impulses aroused by the seductive situation. But in so far as their superego structure was impaired and repression failed, the prisoners found themselves struggling against relapses into a "delinquent" ego state in which they felt—and actually were—identified with the hated, worthless criminals. Then the defense was directed no longer against bad impulses, but against bad body parts or against the "criminal" self *in toto,* which were split off and put out of existence.

In my paper on "Denial and Repression" I discussed also the hypercathexis of perception, which in depersonalized states becomes evident in the watching ego. I described there Mr. C.'s craving to observe the woman's delighted facial expression during intercourse. Whereas his watching intended to undo and deny female castration, his original sadistic wish to expose the defect would occasionally break through. During actual intercourse he would hardly ever gratify his desire but, instead, would become depersonalized and "watch" himself perform. Here we can see that the self-observation in depersonalization absorbs and transforms the original sadistic-voyeuristic impulse toward the woman and, turning it to the self, employs it for a denial of the identification with this castrated object.

Oberndorf (17) also laid much stress on the superego pathology in such patients. I am certainly inclined to accept his assumption that their superego frequently shows a lack of uniformity and stability. But his thesis was that the superego shows discrepancies because of unacceptable superego identifications with the parental figure of the opposite sex. My observations do not wholly confirm this opinion. In Mrs. A.'s case the depersonalization certainly arose from the conflict between her phallic and her unacceptable masochistic identifications with the "castrated" child. Inasmuch as they were expressive of a masculine-aggressive versus a feminine ideal, Oberndorf's assumption seems to be applicable. However,

I believe that the contradictory qualities of the superego in such patients are caused by discrepancies arising from drive intrusions into the ego ideal. In all my cases, these contradictions developed under the influence of a defective parental superego; but this may not be so in general.

This leads us to the final points; i.e., to the relations between depersonalization and (melancholic) depression, and to the different identification mechanisms in these two states.

Both develop from narcissistic conflicts and both seem to presuppose object relations of a narcissistic nature. But the conflict in depersonalization certainly is quite different in structure from the conflict in depression. In both, depression and depersonalization, identification processes bring about an inner schism. However, in depression the schism develops between the punitive, sadistic superego and the ego or the self-image, respectively. In depersonalization the superego need not even take part in the conflict, as was shown by the case of Mrs. A. But apparently in many of these patients, contradictions in the superego lead to a schism in the ego or self, respectively. Instead of a punishing superego accusing the worthless self, we therefore find in depersonalization a detached, intact part of the ego observing the other —emotionally or physically dead—unacceptable part.

We remember that Nunberg (13) could interpret the complaints of severely depersonalized patients as castration complaints, and that he pointed to the equation of the ego with the genital. This is in harmony with my findings which, however, additionally show that the deflated, castrated ego part becomes estranged, dead, because it is identified with devalued, castrated object images. In depression the superego directs the hostility against the whole ego or self, respectively. In depersonalization a part of the ego employs aggression for the elimination of the "bad" ego part. This again confirms Oberndorf's (17) statement that depersonalization means "playing dead." We may question how, under such circumstances, depersonalization can develop in the frame of depression. But the answer is not difficult. The superego and part of the ego can easily join forces in their fight against the worthless, degraded, infantile self. This has been emphasized by Bergler and Eidelberg (2). However, they believe that, in depersonaliza-

tion, part of the ego always offers its services to the superego and that the ego uses its own weapons to defeat itself. I believe that this view is valid only in special cases. I think that my conclusions are in agreement with the views expressed by Blank (4).

One more remark, concerning states of depersonalization in schizophrenics. It is my impression that in the case of chronic schizophrenic processes, experiences of depersonalization, which mostly occur in the beginning of the illness, are indicative of sudden mobilizations of regressive processes. The opinion has been voiced that depersonalization represents a restitutive process. However, I believe that even in psychotics it must be regarded as a defense of the ego which tries to recover and to maintain its intactness by opposing, detaching, and disowning the regressed, diseased part.

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